DD-191-PF (1-04)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

INCIDENT REPORT

Please Print ***Confidential Information***

• Division staff may use this form to ensure all pertinent incident information is gathered.
• Providers may use this form or write all pertinent incident information on a separate report to the Division.

INDIVIDUAL'S NAME *(Last, First, M.I.)*	ASSISTS ID NO.	BIRTHDATE

INDIVIDUAL'S ADDRESS *(No., Street, City, State, ZIP)*	FOSTER CARE
	☐ Yes ☐ No

PROVIDER NAME AT TIME OF INCIDENT *(Qualified Vendor, Individual Independent Provider, Provider Site Name)*

NAME AND LOCATION OF INCIDENT *(Site Name, No., Street, City State, ZIP)*	DATE OF INCIDENT	TIME OF INCIDENT ☐ AM ☐ PM

STAFF/WITNESS(ES) INVOLVED IN INCIDENT *(Last, First, M.I.)*	PHONE NUMBER	IMMEDIATE SUPERVISOR
1.		☐ N/A
2.		☐ N/A

DESCRIBE INCIDENT THOROUGHLY. *(What happened before, during and after the incident. Include all known facts, causes of injury and emergency measures, if applicable. Write clearly, objectively and in order of occurrence, without reference to the writer's opinion.)*

WHAT HAPPENED BEFORE THE INCIDENT?

WHAT HAPPENED DURING THE INCIDENT?

WHAT COULD HAVE PREVENTED THE INCIDENT?

Form is continued on reverse (page 2)

Persons with a disability may request a reasonable accommodation such as a sign language interpreter. Requests should be made as early as possible to allow time to arrange the accommodation. This document is available in alternative formats by contacting 602-542-6825.

INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE OF INCIDENT

TYPE OF MEDICAL INTERVENTION *(Doctor's visit, urgent care, emergency room, hospitalization)*

LOCATION OF MEDICAL INTERVENTION *(Site location and address)*

NOTIFICATIONS

Serious incidents, as described in the Division's Policy and Procedures Manual Administrative Directive 76, are to be reported and written as soon as possible, but no later than 24 hours after the incident.

All other incidents, as described in the Directive, must be reported to the District office by the close of the next business day following the incident.

PARENT/GUARDIAN NOTIFIED *(If Yes, name of person notified. If No, explain why)*	NOTIFIED BY WHOM *(Last First, M.I.)*	DATE/TIME OF NOTIFICATION
☐ Yes ☐ No ☐ N/A		☐ AM ☐ PM
SUPPORT COORDINATOR NOTIFIED ☐ Yes ☐ No ☐ N/A		☐ AM ☐ PM
CHILD/ADULT PROTECTIVE SERVICES NOTIFIED ☐ Yes ☐ No ☐ N/A		☐ AM ☐ PM
TRIBAL SOCIAL SERVICES NOTIFIED ☐ Yes ☐ No ☐ N/A		☐ AM ☐ PM
POLICE NOTIFIED ☐ Yes ☐ No ☐ N/A		☐ AM ☐ PM

PRINT NAME OF PERSON COMPLETING THIS FORM	SIGNATURE OF PERSON COMPLETING FORM	DATE

CORRECTIVE ACTION/COMMENTS

WHAT STEPS ARE BEING TAKEN TO PREVENT THIS FROM HAPPENING AGAIN?

PRINT SUPERVISOR'S NAME	SIGNATURE OF SUPERVISOR	DATE